

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address:	MFDR Tracking #:	M4-06-6575-01
EDINBURG REGIONAL HOSPITAL 3255 W PIONEER PKWY ARLINGTON TX 76013-4620		
Respondent Name and Box #:		
WC Solutions Box #: 19		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the APC rate of \$1,479.58 for APC #0041. Allowing this at 140% would yield a fair and reasonable allowance of \$2071.41. Based on the payment of \$1268.84 a supplemental payment is still due of \$802.57."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$802.57
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Respondent did not submit a response.

Principle Documentation: None.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/28/2005	18, 97, W10, W4	Outpatient Surgery	\$802.57	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - 18 – "Duplicate claim/service."
 - 97 – "Payment is included in the allowance for another service/procedure."
 - W10 – "No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology."
 - W4 – "No additional reimbursement allowed after review of appeal/reconsideration."
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011"...

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. The Division notified the carrier of the request for medical fee dispute resolution on June 21, 2006. Per Division rule at 28 TAC §133.307(e)(3)(C), the respondent shall "file the completed request with the division and the requestor within fourteen (14) calendar days of respondent's receipt of the request." Review of the submitted documentation finds that no response from the carrier has been received for consideration in this dispute. Therefore the dispute will be reviewed according to the documentation available at the time of review.
5. Division rule at 28 TAC §133.307(g)(3)(C), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including "a statement of the disputed issue(s) that shall include: (i) a description of the healthcare for which payment is in dispute, (ii) the requestor's reasoning for why the disputed fees should be paid or refunded, (iii) how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues, and (iv) how the submitted documentation supports the requestor position for each disputed fee issue. This request for medical fee dispute resolution was received by the Division on June 16, 2006. Pursuant to §133.307(g)(3), the Division notified the requestor on June 21, 2006 to send the additional required documentation. Review of the submitted documentation finds that the requestor did not discuss or explain how the Texas Labor Code and Division rules impact the disputed fee issues, or how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C).
6. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines)". The requestor asserts in the position statement that "Medicare would have reimbursed the provider at the APC rate of \$1,479.58 for APC #0041. Allowing this at 140% would yield a fair and reasonable allowance of \$2071.41." Review of the documentation finds that the requestor did not discuss or explain how it determined that 140% of the Medicare rate would yield a fair and reasonable reimbursement. Nor did the requestor submit evidence to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011 or 28 TAC §134.1. Additionally, the requestor did not provide documentation to support the Medicare payment calculation. Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. The request for additional reimbursement is not supported.
7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(C) and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.